Northwest Functional Neurology

Dr. Glen Zielinski DC, DACNB, FACFN
17449 Lower Boones Ferry Road, Suite 300 Lake Oswego OR 97035 503-850-4526

DEMOGRAPHCS

Last Name: _____ First Name: _____ MI: _____

Date of Birth _____/_____/_____ Gender: _____ SS#: _____

Home Address: _____ Apt#: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ - _____ - _____ Cell: _____ - _____ - _____ Work: _____ - _____ - _____

E-mail: _____ how did you hear about us? _____

Where can we leave a message: _____ Primary Doctor: _____

SOCIAL HISTORY (Circle ONE that applies):

EMPLOYMENT STATUS: EMPLOYED UNEMPLOYED RETIRED HOMEMAKER MARITAL STATUS: MARRIED SINGLE OTHER MINOR/CHILD

LIVING SITUATION: ALONE COHABITING and APARTMENT HOUSE

EMPLOYMENT INFORMATION (does not apply for minor)

Employer Name: _____ Employer Phone: _____

Employer Address: _____ City: _____ Zip: _____

EMERGENCY CONTACT

Contact Name: _____ Relation to patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ - _____ - _____ Cell Phone: _____ - _____ - _____

MY CERTIFICATION

I certify that the above information is correct and I request services.

MY PRIVACY

I have received a copy of the Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: conduct, plan and direct my treatment and follow-up among the healthcare providers who may be directly and indirectly involved in providing my treatment; Obtain payment from third-party payers; conduct normal healthcare operation such as quality assessment's and accreditation.

_____ _____

Signature of Patient, Guardian or Personal Representative Date

Northwest Functional Neurology
Glen Zielinski, DC, DACNB, FACFN
Board Certified Chiropractic Neurologist
17449 Lower Boones Ferry Road, Suite 300 • Lake Oswego, Oregon 97035
Telephone: 503.850.4526 • Facsimile: 503.908.1555

HIPAA EMAIL CONSENT

- HIPAA stands for the *Health Insurance Portability and Accountability Act*
- Northwest Functional Neurology offers our patients the ability to communicate with us via email.
- Information stored on our computers is encrypted.
- Most popular email services (Hotmail, Gmail, Yahoo) do not utilize encrypted email.
- However, email is not always the most secure and confidential way of communicating.
- HIPAA guidelines state that if a patient has been made aware of the risks of unencrypted email, and that same patient provides consent to receive health information via email, then a health entity may send that patient personal medical information via unencrypted email.

OPTION 1 – ALLOW UNENCRYPTED EMAIL

I understand the risks of unencrypted email and do hereby give permission to Northwest Functional Neurology to send me personal health information via unencrypted email.

_____ _____ _____

Signature Date Printed name

(parent or guardian if patient is a minor)

OPTION 2 – DO NOT ALLOW UNENCRYPTED EMAIL

I do not wish to receive personal health information via email.

_____ _____ _____

Signature Date Printed name

(parent or guardian if patient is a minor)

APPOINTMENT CONFIRMATIONS

How do you wish to receive appointment reminders?

☐ Send confirmations via ***email***: _____

☐ Send confirmations via ***text*** (must be a Mobile phone): _____

☐ Send confirmations via ***phone call*** (Home or Mobile): _____

Northwest Functional Neurology

Dr. Glen Zielinski DC, DACNB, FACFN

POLICY ON PATIENT ACCOUNTS AND CONDITIONS OF TREATMENT

Northwest Functional Neurology is a private institution that operates for the benefit of people who seek the services of our medical staff. We provide quality care at what we believe to be a fair and reasonable fee. Since we do not receive financial assistance from any outside source we must recover the cost of providing services for our patients. It is our policy, that the responsibility of paying for care, will be placed upon those who receive it; therefore, all accounts will be under the following guidelines:

1. Missed Appointment(s): If you are unable to keep a scheduled appointment we require sufficient time (24 hours) to fill that time spot. If you NO SHOW or do not call 24hrs in advance, you may be charged a $40 fee, which is at the discretion of Northwest Functional Neurology.

2. Cost of Service(s): The cost of service(s) rendered varies based on the extent, focus and testing required at your visit. Some of the services or supplies offered or suggested by this office may be considered non-covered items under your insurance plan; you will be held responsible for these services and /or supplies at the time of service.

3. SELF-PAY: Any self-paying patient will be required to pay charges for their visit and the obligation to pay for medical services may not be deferred for ANY reason. A 20% discount is offered to self-pay patients at the time of service (same-day). However, if payment is not made at the time of service the FULL amount will be billed.

4. Payment Options: Payment options include cash, check, Visa, MasterCard, American Express, money order, traveler's check or certified check.

5. Account Balance: If you have a balance on your account you will receive monthly statements until the account is paid in full. Bills are due and payable upon receipt of your statement. It is office policy to not hold any balances.

6. INSURANCE: Our office does not bill commercial insurance. For your convenience we will provide you with a statement that includes our diagnosis codes and billed charges. This will allow you to submit our charges to your insurance company to seek reimbursement. We are unable to guarantee reimbursement, as this is a matter between you and your insurance company

7. Authorization for disclosure of information: I _____ hereby authorize, Dr. Glen Zielinski and his team, to disclose all or part of the medical record of (patient's name) _____ to any company that may be responsible for payment of all or part of this patient's medical charges. Disclosure of records may be necessary to determine eligibility for liability that may arise from disclosure of these records. I understand that I may revoke this authorization at any time in writing except to the extent that Northwest Functional Neurology has already taken action on my claim.

_____
PRINT PATIENT'S NAME

X_____ _____
SIGNATURE OF PATIENT OR RESPONSIBLE PARTY DATE

17449 Lower Boones Ferry Road, Suite 300 Lake Oswego OR 97035 503-850-4526

Northwest Functional Neurology

Dr. Glen Zielinski DC, DACNB, FACFN

INFORMED CONSENT

I _____ consent to the performance of neurology treatments and any other associated diagnostic procedures. I consent to physical examinations, tests, diagnostic x-ray, physiotherapy, and rehabilitation for neurologically based symptoms, on me, by the doctor of functional neurology and or his assistants and/or his other licensed practitioners within Northwest Functional Neurology.

I understand, as with any health care procedures, that certain complications may arise during chiropractic functional neurology treatments. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Homers' syndrome, diaphragmatic paralysis, cervical myelopathy, costovertebral strains and separations. Some types of manipulations of the neck have been associated with injuries to the arteries in the neck leading to or contributing to complications including stroke.
I do not expect the doctor to be able to anticipate all risks and complication and I wish to rely upon the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon facts then known, that are in my best interest.

I understand that I will have the opportunity to discuss with the doctor(s) at Northwest Functional Neurology, and/or with office personnel, the nature and purpose, as well as, risks, of neurology treatments and other recommended procedures. I also understand that specific results are not guaranteed.

By signing below, I give my consent for treatment of my present condition(s) and for any future condition(s) for which I seek treatment.

_____

PRINT PATIENT NAME

_____ _____

SIGNATURE OF PATIENT OR REPRESENTATIVE DATE

_____

OFFICE SIGNATURE

Northwest Functional Neurology

GLEN ZIELINSKI DC, DACNB, FACFN

PATIENT HEALTH INFORMATION CONSENT FORM

Northwest Functional Neurology wants you to know how your Patient Health Information (PHI) will be used in this office and what your rights are concerning those records. Before we will begin any health care operations we require you to read and sign this consent form stating that you understand and agree with how your records will be used. For more information you may refer to the HIPPA PRIVACY NOTICE that you received with the initial intake packet.

1. The patient understands and agrees to allow Northwest Functional Neurology to use their PHI for the purpose of treatment, payment, healthcare operations and coordination of care. At your request, our office will release all PHI for correspondence with other healthcare providers and insurance companies.

2. The patient has the right to examine and obtain a copy of his/her own health records at any time. The patient may request corrections and to know what disclosures have been made and may submit, in writing, any further restrictions on the use of their PHI. However, changes and restrictions made and agreed to by us must be within the scope of State and Federal laws.

3. The patient's written consent need only be obtained one time for all subsequent care given at Northwest Functional Neurology.

4. The patient may provide a written request to revoke consent at any time during their care. Please note: this request would only apply to records from the date of the request forward, and does not include use of records prior to the request.

5. Northwest Functional Neurology may contact you periodically regarding appointments, treatments, products, services, payments or charitable work performed. You have the right to "opt-out" of any marketing or fundraising communications at any time.

6. Northwest Functional Neurology enforces the "right to privacy". All our staff is trained in handling patient records and enforcing privacy. A privacy official has been designated to ensure those procedures are implemented and adhered to in our office. Your records are not readily available to those who do not need them.

7. The patient has a right to file a formal complaint with our privacy official and with the Secretary of HHS about any possible violations of these policies and procedures, without retaliation by Northwest Functional Neurology.

8. Northwest Functional Neurology reserves the right to make changes to this notice and make new notice provisions effective for all protected health information that it maintains. If changes are made, you will be provided with the new notice.

9. Refusal to sign this consent may result in Northwest Functional Neurology's right to refuse care.

I, _____, have read and understand how my
Patient name or Patient Representative

PATIENT HEALTH INFORMATION (PHI) will be used and agree to the above policies and procedures.

_____ _____
Patient or Patient Representative's Signature Date

17449 Lower Boones Ferry Road, Suite 300, Lake Oswego, OR 97035
503-850-4526 Fax: 503-908-1555

NORTHWEST FUNCTIONAL NEUROLOGY
NOTICE OF DOCTOR LIEN

Patient: _____ Date: _____

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him for the medical service rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate NORTHWEST FUNCTIONAL NEUROLOGY. And I hereby further give a Lien on my case to NORTHWEST FUNCTIONAL NEUROLOGY against any and all proceeds of my settlement, judgment, or verdict which may be paid to you, my attorney, or myself, as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to NORTHWEST FUNCTIONAL NEUROLOGY for all medical bills submitted for service rendered me. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

_____ _____

DATED PATIENT'S SIGNATURE

_____ _____

DATED OFFICE SIGNATURE

AUTO ACCIDENT INTAKE

NAME: _____ Date:_____

DATE OF BIRTH: _____

AUTO INSURANCE: _____

CLAIM NUMBER #: _____

ADJUSTER: _____

	Yes	No
Have you retained an attorney?	☐	☐

Name/Telephone: _____

Nature of Accident

Date of Accident: _____ Time: _____

State where the accident took place: _____ Vehicle: _____

Were you: ( ) Driver ( ) Passenger ( ) Front Seat ( ) Back Seat

Number of People in Your Vehicle: _____ Other Vehicle: _____

Direction you were headed: ( ) North ( ) East ( ) South ( ) West

on (name of street) _____

Direction other vehicle headed: ( ) North ( ) East ( ) South ( ) West

on (name of street) _____

Were you struck from: ( ) Behind ( ) Front ( ) Left side ( ) Right side

Were you knocked unconscious?: ( ) Yes ( ) No. If yes, for how long?: _____

In your own words, please describe the accident _____

_____

_____

Did you have physical complaints BEFORE the accident? ( ) Yes ( ) No

If yes, please describe in detail: _____

_____

_____

Please describe how you felt:

DURING the accident: _____

IMMEDIATELY AFTER the accident: _____

LATER THAT DAY: _____

THE NEXT DAY: _____

Do you have any previous injuries/illnesses which relate to this case?: _____

_____

Have you ever been involved in an accident before?: ( ) Yes ( ) No. If yes, please describe, including date(s) and type(s) of accidents, as well as injury(ies) received: _____

_____

_____

Where were you taken after the accident?: _____

Have you been treated by another doctor(s) since the accident?: ( ) Yes ( ) No. If yes, please list doctor's name(s): _____

What type of treatment did you receive?: _____

Since this injury occurred, are your symptoms: ( ) Improving ( ) Getting Worse ( ) Same

Check Symptoms You Have Noticed Since The Accident:

☐	Headache	☐	Sleeping Problems	☐	Numbness in Toes	☐	Sensitivity to Light	☐	Hands Cold
☐	Neck Pain	☐	Chest pain	☐	Shortness of Breath	☐	Loss of Balance	☐	Stomach Upset
☐	Neck Stiff	☐	Dizziness	☐	Fatigue	☐	Fainting	☐	Constipation
☐	Irritability	☐	Head Seems Heavy	☐	Depression	☐	Loss of Smell	☐	Cold Sweats
☐	Back Pain	☐	Pins/Needles in Arms	☐	Face Flushed	☐	Loss of Taste	☐	Fever
☐	Nervousness	☐	Pins/Needles in Legs	☐	Loss of Memory	☐	Diarrhea		
☐	Tension	☐	Numbness in Fingers	☐	Ears Ring	☐	Feet Cold		

Symptoms other than above: _____

Have you lost time from work as a result of this accident?: ( ) Yes ( ) No. If yes, please complete the following

Last Day Worked: _____

Type of Employment: _____

Did you notice any activity restrictions as a result of this injury?:( ) Yes ( ) No. If yes, please describe in detail:

_____

_____

_____

Please list any other pertinent information:

_____

_____

_____

_____

Your Health History

Please take the time to fill in this information. It really helps streamline our time together.

Name: _____ Date:_____

Age: _____ Date of Birth: _____ Occupation: _____

How long has it been since your last medical evaluation?: _____
Do you follow any special diet? If yes, please describe: _____

	Yes	No	
Tobacco?	☐	☐	If yes, how much/many per day? _____ for how many years have you used tobacco? _____
Alcohol?	☐	☐	If yes, how many drinks per week? _____
Caffeinated drinks?	☐	☐	How many per day? _____
Regular exercise?	☐	☐	Please describe: _____ _____

Please list any **allergies** or **sensitivities** to medications: Tic here if none: ☐

Allergy:	**Type of reaction:**
_____	_____
_____	_____
_____	_____

If you have personal reasons to not receive blood products, please tick here: ☐

Current Medications (prescription & non-prescription, please include dose):

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Herbs or supplements

_____ _____
_____ _____
_____ _____
_____ _____

Please turn page over and continue

Personal Medical History: *Please tick the appropriate box*

	Yes	No		Yes	No
High blood pressure:	☐	☐	Gastrointestinal disorder:	☐	☐
Cholesterol problems:	☐	☐	Acid reflux:	☐	☐
Heart disease:	☐	☐	Stomach ulcer:	☐	☐
type: _____			Hepatitis:	☐	☐
Thyroid disorder:	☐	☐	Irritable bowel	☐	☐
Diabetes: type: _____	☐	☐	Frequent bladder infections:	☐	☐
Kidney disease:	☐	☐	Incontinence:	☐	☐
Anemia:	☐	☐	Respiratory problems:	☐	☐
Bleeding/clotting disorder:	☐	☐	Asthma:	☐	☐
Stroke:	☐	☐	Seasonal allergies:	☐	☐
Skin disorder:	☐	☐	Sleep problems:	☐	☐
type: _____			Serious infections:	☐	☐
Cancer:	☐	☐	Chronic pain:	☐	☐
type: _____			location of pain: _____		

Other illnesses: _____

Please list any **surgeries**: _____

_____

Have you had any recent **accidents**? Yes ☐ No ☐

If yes, please describe: _____

Do you have a tendency for depression? Yes ☐ No ☐

If yes, what treatment has been helpful? _____

Family History:

	relationship to you		relationship to you
Diabetes	_____	Alcoholism	_____
Heart disease	_____	Depression	_____
High blood pressure	_____	Bleeding disorder	_____
High Cholesterol	_____	Strokes	_____
Prostate cancer	_____	Arthritis	_____
Breast cancer	_____	Thyroid disease	_____
Other cancers	_____	Osteoporosis	_____

Please specify any specific issues or problems you would like to address today:

_____

_____

_____

_____